South West Yorkshire Partnership NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

Fieldhead Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXGDD	Priestley Unit	Ward 18	WF13 4HS

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

All patients were protected from potential harm and abuse. Patients individual needs were met through timely risk assessments, that were reviewed and updated regularly. The service had enough staff with the right training and support to deliver safe care and treatment.

Regular assessment of environmental risk ensured facilities and equipment were safe for patients and staff.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Ratings have not been given for this inspection.

We found;

- Environmental risk assessments on the ward were up to date and accessible to staff. This meant staff were aware of identified risks on the ward and the action required to mitigate these.
- The ward had sufficient numbers of adequately trained and competent staff.
- Staff completed risk assessments for all patients on admission, reviewed and updated the risk assessment regularly.
- The use of restrictive interventions had decreased in the six months prior to this inspection.
- Staff reported incidents and learned from them when things went wrong.
- Staff consistently carried out and recorded the necessary reviews of patients in seclusion as outlined in the trust policy and the Mental Health Act Code of Practice.
- Staff recorded if a debrief was provided following an incident or the use of restrictive interventions such as restraint.
- All wards had access to fully equipped and organised clinic rooms. The storage and administration of medication was appropriate.
- The ward was clean and adequately maintained. This location scored highly on the patient led assessment of care environments.

However;

- Two care plans did not include up to date information from the risk assessment.
- Patients did not have access to a nurse call system in the event of an emergency.

Are services effective?

We inspected specific key lines of enquiry in relation to the Mental Health Act and we found;

- All section 17 leave had been authorised by the responsible clinician and documented appropriately.

However;

- There was no clear record of families, carers' or others accompanying patients, having received a copy of the section 17 leave authorisation.

Summary of findings

• Staff did not complete the section 17 leave authority correctly.	
Are services caring? We did not inspect this domain as we had no concerns regarding these key lines of enquiry.	
Are services responsive to people's needs? We did not inspect this domain as we had no concerns regarding these key lines of enquiry.	
Are services well-led? We did not inspect this domain as we had no concerns regarding these key lines of enquiry.	

Summary of findings

Information about the service

South West Yorkshire Partnership NHS Foundation Trust provides acute inpatient services for men and women aged 18 and over. Services are provided at Fieldhead; Wakefield, Priestley Unit; Dewsbury, The Dales; Halifax and Kendray Hospital in Barnsley.

Fieldhead in Wakefield provides three acute inpatient wards. These are:

- Stanley Ward a 22 bed male acute admission ward
- Priory 2 a 22 bed female acute admission ward
- Walton Ward a 14 bed psychiatric intensive care unit

Priestley Unit in Dewsbury has one acute inpatient ward. This is:

- Ward 18 a 23 bed mixed acute admissions ward

The Dales in Halifax has two acute inpatient wards. These are:

- Elmdale Ward a 24 bed female acute admissions ward
- Ashdale Ward a 24 bed male acute admissions ward

Kendray Hospital in Barnsley has three inpatient wards. These are:

- Beamshaw Ward a 14 bed male acute admission ward
- Clarke Ward a 14 bed female acute admission ward
- Melton Suite a 6 bed psychiatric intensive care unit.

South West Yorkshire Partnership NHS Foundation Trust have been registered with the Care Quality Commission since 2009 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- diagnostic and screening procedures
- nursing care

The service was able to admit patients who were detained for treatment under the Mental Health Act (1983), those with Deprivation of Liberty safeguards in place and informal patients. The majority of patients were detained under the Mental Health Act at the time our inspection, there were no patients with Deprivation of Liberty safeguards in place.

We have carried out seven Mental Health Act monitoring visits across the service between January 2017 and November 2017. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously inspected the acute and psychiatric intensive care unit services between 30 January and 2 February 2017. The inspection report was published 13 April 2017 and we found some areas for improvement. We rated the service as requires improvement in two key questions (safe and effective) and rated the service as 'good' in caring, responsive and well led. Following the inspection in January 2017 the service was rated as requires improvement overall.

Our inspection team

Team leader: Joanne White, Mental Health Hospitals Inspector, Care Quality Commission. The team that inspected the service comprised three CQC inspectors, which included the team leader and one Mental Health Act reviewer.

Summary of findings

Why we carried out this inspection

This inspection was a responsive inspection of Ward 18, Priestley Unit, Dewsbury following on from information of concern received by the CQC. We looked at all the key lines of enquiry within the safe domain and selected key lines of enquiry from the effective domain.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about this service and requested information from the trust.

During the inspection visit, the inspection team:

- visited Ward 18, looked at the quality of the environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the general manager, practice governance coach, ward manager and responsible clinician
- spoke with seven other staff members including nurses, healthcare support workers, pharmacy staff, occupational therapist, psychologist and housekeeper
- looked at the care and treatment records of five patients
- reviewed medication management including the medication administration records of five patients
- looked at policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure the ward is compliant with Department of Health's national guidance on eliminating mixed-sex accommodation.
- The trust should ensure all care plans include accurate and up to date information relating to the risk assessment.
- The trust should ensure staff are competent in the management of section 17 leave authority forms and a record is made of section 17 leave authorisations given to other people, including family members or carers.
- The trust should ensure patients have access to a nurse call system in the event of an emergency.
- The trust should consider how it appropriately displays confidential patient information.

South West Yorkshire Partnership NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 18	Priestley Unit

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the ward layout

The ward had an environmental suicide and ligature point risk assessment tool which was a newly introduced tool for assessing ligature risks. The assessment had been completed in October 2017 and was in the process of being signed off by the senior management team. Rooms on the ward had been individually assessed for ligature risks and a risk rating was calculated for each potential ligature risk. The service manager told us that the ligature risk assessment and the resulting action plan was to be agreed in January 2018. The ligature risk assessment included individual controls for ligature risks including individual care plans, staff awareness and observation levels.

The layout of the ward presented some challenges to staff when observing all areas. The ward had blind spots on both bedroom corridors; the use of observation mirrors adequately mitigated this risk. A small corridor previously used to access outside space remained an ongoing risk. Two visiting rooms and a store room were located on the corridor. The service had identified these risks on the environmental suicide and ligature point risk assessment tool completed in October 2017. Staff awareness and regular observation mitigated this risk, as these blind spots were in a communal area.

The ward was last inspected by the trust's fire safety officer in January 2017. There was a fire risk assessment available on the ward which was first completed in 2012 and had been reviewed and updated annually since 2014.

There was access to appropriate alarms for staff to use in the event of an emergency. Patients did not have access to a nurse call system, this meant patients could not make staff aware of their needs in an emergency.

The ward complied with the Department of Health's national guidance on eliminating mixed-sex accommodation. Both men and women had separate corridors and bathroom facilities. The ward also had separate lounges for men and women. On 22 November 2017 we completed a Mental Health Act Monitoring visit and identified there were still occasions when male patients were being located in rooms on the female corridor due to patient numbers. During this inspection no male patients were admitted into female beds. One patient told us that male patients had been admitted into an allocated female bed and staff had carried out observation on the corridor 24 hours a day.

Maintenance, cleanliness and infection control

The ward was clean, well maintained and furnishings were good. Housekeeping and domestic staff were visible on the ward and all cleaning schedules were on display. The ward participated in the 2017 patient led assessment of the care environment. These assessments are self-assessments undertaken by teams of trust staff and specially trained members of the public. They focus on different aspects of the environment in which care was provided. For cleanliness the ward scored 100%. For condition, appearance and maintenance, the ward scored 91%.

Housekeeping staff participated in a monthly walk around with facilities staff to audit the ward cleanliness. A monthly report was produced and outcomes shared with domestic staff. The trust set the target to achieve at 95%. In November 2017 the ward achieved 93% compliance and December 2017, 87%. The ward manager told us the cleanliness of the ward was not as expected and this had been addressed by the appointment of a permanent member of domestic staff.

We observed staff following infection control principles. There were hand gel dispensers across ward and we observed staff using these. Effective hand washing guidance was visible in toilets and bathrooms. Personal protective equipment was available and was stored securely.

Seclusion room

The seclusion room had an intercom that allowed for two way communication and patients were able to see a clock which showed the correct time. During a visit by a Mental Health Act reviewer on 22 November 2017 it was noted that natural daylight and the view outside the room was diminished by a dark plastic screen. Prior to this inspection the trust had replaced this with a clear panel that now provided good natural light. The room had variable heating that could be adjusted by staff outside the room. The

seclusion room did not have adjustable lighting; the light was either on or off. The seclusion room had an en-suite shower and toilet facilities. Staff could adequately observe patients at all times.

Clinic room and equipment

The clinic room was well organised, fully stocked and clean. We saw "I'm clean" stickers on equipment, identifying when it was cleaned and by whom. The clinic room had an examination couch and this meant all patients could be physically examined in a clinical room. A blood pressure monitor, weighing scales, resuscitation equipment and emergency drugs were available. We saw the required checks of resuscitation equipment and emergency drugs had been completed. Staff regularly checked medicine fridge temperatures and recorded these.

Information was on display in relation to physical health monitoring of patients, including the type of physical observation and frequency required. This meant patients potentially could be identified by their initials and confidentiality breached.

Safe staffing

Nursing staff

During this inspection the ward had sufficient staff on duty to provide safe care and treatment, including nurses, support workers, a psychiatrist, an occupational therapist and activity workers. The ward had 17 whole time equivalent qualified nurses and had a vacancy rate of 12% for qualified nurses (two vacancies). The ward had 15 whole time equivalent nursing assistants and had no vacancies.

The sickness rate was 6% for June to December 2017 which was above the average NHS sickness rate of 4%. The trust also provided sickness rates which showed that the average sickness rate had not changed from 6% between October 2016 and October 2017.

The turnover rate was 8% which was the result of two members of staff leaving in the last six month period between June to November 2017. There were 3777 shifts in total from 1 May 2017 to 31 October 2017. Of these, 3644 were covered by regular staff, 738 (20%) were covered by bank or agency staff and 133 (4%) could not be covered by bank or agency where there was sickness, absence or vacancies. The ward manager told us they could adjust the staffing levels to take account of the acuity of patients on the ward. Managers received a weekly update and monthly report on staffing, this provided oversight to the management team.

Bank and agency staff received appropriate induction. A senior manager told us the ward used regular bank staff to maintain consistency and continuity for patients and the wider staff team. Staff we spoke with told us the ward was generally well staffed but acknowledged this changed due to the acuity of patients. Staff worked flexibly within the team to ensure patients had dedicated time with their named nurse on duty and could use authorised time off the ward. Activities on the ward were rarely cancelled as the ward had a dedicated therapy team covering six days each week. Staff told us there were enough staff to carry out physical interventions and that staff from an adjacent ward could provide additional support if required.

Medical staff

The ward had a dedicated full time consultant psychiatrist, staff grade doctor and junior doctors who provide medical cover on the ward. There was access to a doctor 24 hours per day who could attend the ward quickly in an emergency, as the ward was based on the site of a general hospital with an emergency department.

Mandatory training

Staff were required to undertake 13 modules of mandatory training. Mandatory training compliance by module was:

- Aggression management – 86%
- Cardiopulmonary resuscitation – 80%
- Clinical risk – 86%
- Equality and diversity – 86%
- Fire safety – 87%
- Food safety – 65%
- Infection control and hand hygiene – 74%
- Information governance – 94%
- Moving and handling – 91%
- MCA & DOLS – 91%
- Mental Health Act – 90%
- Safeguarding Adults – 74%

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Safeguarding Children - 69%
- Sainsbury's Tool – 79%

The trust target for mandatory training compliance was 80% for all modules with the exception of information governance. The trust target for information governance training, which was an annual course, was 95%. The average compliance rate for mandatory training for all modules with the exception of information governance training was 82% up to November 2017. This was above the trust's mandatory training target. The compliance rate for information governance was 94% which was 1% lower than the trust's target. Modules below 75% compliance were infection control and hand hygiene, safeguarding adults and safeguarding children. The ward manager told us that staff that were out of date with safeguarding children and safeguarding adults training had dates booked on courses in 2018. The service monitored compliance with mandatory training regularly in service line meetings.

Assessing and managing risk to patients and staff

Assessment of patient risk

The service had a policy to provide guidance for staff on clinical risk assessment and management. The service used a standardised risk assessment tool to support clinical risk management and this was based on Best Practice in Managing Risk guidance (Department of Health, 2007).

During this inspection we reviewed five care records. All five patients had a risk assessment completed upon admission. On the day of this inspection, all five risk assessments were up to date and had been regularly reviewed in line with trust policies and procedures.

Management of patient risk

With the exception of two, all care records reviewed had been updated by staff in response to a change in patient risk. For example, risk assessments had been updated to reflect that patients were being supported on increased levels of observation due to their increased risk, or updated following a psychiatry review. We saw evidence of one risk assessment initially completed in October 2017 being updated by staff on three further occasions. The identified risk of absconsion was not recorded in one of the patients care plan and this did not comply with trust policy for clinical risk assessment and management. A second care record had not been updated following an incident of deliberate self-harm.

Staff followed trust policy on searching patients'. The ward displayed a list of restricted items so patients were informed of what they could have in their possession. Staff did not routinely search patients entering or exiting the wards for the purpose of section 17 leave. Staff told us they would discuss their concerns with the nurse in charge or a senior manager regarding the need to search a patient.

The trust had an observation and engagement policy to support and protect patients and staff. We saw staff regularly and consistently completing general observations of patients on the ward, as required by trust policy. Staff told us that a member of staff was allocated this role at the commencement of each shift. We saw evidence that these checks were documented by staff upon completion of each hourly check.

We saw evidence that the trust had applied a blanket restriction in relation to the use of bathrooms on the ward, all bathroom doors were externally locked by staff when they were not in use due to ligature risks. This response was proportionate as all patients were individually risk assessed to use bathrooms independently or with supervision.

The trust was committed to a smoke free environment. Patients, staff and visitors were not permitted to smoke on site. Staff and patients we spoke with stated smoking by patients remained a challenge. Between 21 December 2016 and 20 December 2017 there were 79 incidents of smoking related issues reported on the incident reporting system. During this inspection we observed a member of staff challenge a patient smoking in the court yard. We observed that smoking cessation advice was available on the ward.

On the day of this inspection there were nine patients on the ward that were not detained under the Mental Health Act. We observed information clearly on display for patients to see regarding their right to leave the ward.

Use of restrictive interventions

The trust provided the following data on the use of restrictive interventions on Ward 18 from 1 June 2017 to 30 November 2017.

- Number of incidents of the use of restraint – 37

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Total number of service users involved in incidents of restraint – 16
- Number of incidents of the use of prone restraint – 6
- Total number of service users involved in incidents of prone restraint - 3
- Number of incidents of the use of seclusion – 8
- Total number of service users involved in incidents of the use of seclusion - 6
- Number of incidents of the use of rapid tranquilisation – 6
- Number of incidents of the use of long term segregation – 0

The use of restrictive interventions had decreased on Ward 18 since the last inspection. At the last inspection Ward 18 had 87 incidents of restraint between June and December 2016. At this inspection between July and December 2017 there were 37 incidents of the use of restraint. The use of prone restraint had decreased from 26 incidents between June and December 2016 to six uses of prone restraint between July and December 2017. The use of seclusion had decreased from 38 incidents between June and December 2016 eight uses of seclusion between July and December 2017. There were no episodes of long term segregation.

Staff we spoke with understood the definition of seclusion and that restraint should be used only after other de-escalation attempts had been made. Staff were able to describe methods they would use to manage incidents prior to attempting restraint. Staff told us they would only use restraint if it was necessary for the safety of patients and staff.

We reviewed 11 seclusion records from the six months prior to this inspection. Seclusions were all authorised by the nurse in charge and each record included a summary of what attempts to de-escalate had been made prior to the decision to seclude. We saw that there were seclusion care plans in place for all 11 patients, including clear seclusion exit plans. The duration of seclusion episodes varied from 40 minutes to 26.5 hours. Two episodes lasted longer than five hours. Staff appropriately managed patients by completing the required medical, nursing and multi-disciplinary reviews. This meant staff were carrying out the necessary reviews as outlined in the trust policy and the Mental Health Act Code of Practice.

The trust has a Seclusion and Longer Term Segregation Policy which shows that patients must be supported following a period of seclusion and a fully documented seclusion evaluation should be conducted with the patient. All 11 seclusion records included evidence of debriefs being conducted with patients and documented description of why seclusion was no longer necessary.

The trust has a policy for Rapid tranquilisation and PRN (As required medication) Psychotropic Medication which includes guidance for staff on the use of rapid tranquillisation. This policy is underpinned by national guidance from the National Institute for Health and Care Excellence. Rapid tranquilisation is medication which is given in the short term management of disturbed or violent behaviour. The use of rapid tranquilisation had decreased from 20 incidents between June and December 2016 to six uses of rapid tranquilisation between July and December 2017.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

We confirmed with the trust that the ward had made two adult and two child safeguarding referrals to safeguarding specialist advisors within the trust in the six months prior to this inspection. The trust required all staff to complete safeguarding training for adults and children. Overall training compliance was 69% for child safeguarding and 74% for adults. We confirmed staff were booked onto this training in 2018.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

During this inspection we observed that safeguarding information was easily accessible to staff electronically on the intranet and displayed in the main office on the ward. We noted that safeguarding information leaflets were on display for patients and carers to access. All staff we spoke with were able to identify potential safeguarding concerns relevant to the patient group. Staff spoke confidently about how they would respond to such a concern and would seek advice from the trust safeguarding lead.

When children visited the ward there were processes in place to keep them safe. The ward had a visiting room away from the main patient area. The ward manager told us that all patients had individual risk assessments in relation to children visiting the service and these were agreed and discussed within the multidisciplinary team. Three further visitor rooms were available for use by patients on the ward.

Staff access to essential information

The service had a secure electronic system to store and record patient information. Access to the system was password protected. Some patient information remained paper-based, such as physical observation charts and blood test results. The trust confirmed regular bank and agency staff were trained in the use of the electronic care record and were able to access this independently. Agency staff who worked less frequently were expected to handover patient information to regular staff members to record in the patient care record.

Medicines management

We looked at five prescription charts on the ward. We saw evidence of a monitoring system in place for the use of high dose antipsychotic medication and this included additional physical health checks and blood tests. We identified one instance where staff had not undertaken physical observations in relation to high dose antipsychotic monitoring for a patient. We spoke with pharmacy staff based on the ward. They confirmed they attended the ward regularly to support medicines reconciliation, provide clinical support, review prescription charts and completed discharge planning. Pharmacy staff were part of the ward multidisciplinary team and were available to speak with patients on request.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified. Between 21 December 2016 and 20 December 2017 there were two Strategic Information Executive System incidents reported by the ward. On the day of this inspection, investigation of both incidents remained ongoing.

Reporting incidents and learning from when things go wrong

The trust had an electronic system for reporting incidents. Regular bank and agency staff were able to access the incident reporting system. Agency staff working less frequently had to report incidents to regular ward staff. Staff had a clear understanding of what constituted an incident and how to report it.

We reviewed incident data from 21 December 2016 to 20 December 2017and a total of 651 incidents had been reported during this time. The majority of incidents were classified as 'no harm' these included violence and aggression (83), legislation and policy (82), self-harm (55) and medication (38).

The management team on the ward initially reviewed all reported incidents. Incidents meeting the threshold of a serious incident were escalated through the trust process. Incidents that were assessed as not requiring this level of investigation were managed locally at ward level. Staff told us information was received through email following incidents, this included how to access support. Incidents were discussed in team meetings and senior nurse meetings, such as smoking, discharges into the community and serious incidents but team meetings were infrequent, there was no standardised agenda and recorded minutes were brief. A senior manager told us learning from serious incidents was shared with staff at learning events, examining the incident, good practice and recommendations. The ward participated in a learning event in October 2017 in relation to a coroners Regulation 28 notification. The event focussed on improving discharge planning from the ward. Learning from trust wide incidents was also available through the intranet. Staff told us that they were de-briefed following incidents; they told us this was supportive and timely. The psychology service contributed to de-briefs for staff and provided regular informal opportunities to discuss incidents on an individual or group basis.

The Duty of Candour is the requirement that staff are open and honest to patients and/or carers when things go wrong with care and treatment. The trusts customer services

policy: supporting the management of complaints, concerns, comments and compliments provided guidance to staff to effectively manage these requirements. Staff knew about their responsibilities under Duty of Candour.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

We inspected specific key lines of enquiry in relation to the Mental Health Act.

We reviewed all section 17 leave authorisations for the patients detained under the Mental Health Act. All section 17 leave had been properly authorised by the responsible clinician. The conditions attached to the leave were clearly described on the section 17 leave authorisations. There was a record of the authorisation being given to the patient in all cases. We did note there was no clear record of the section 17 leave authorisations being given to other people, including people who were named to accompany the patient. It appeared that staff did not understand the section of the form that asks for 'the following persons have been notified of these arrangements', as on several forms staff had entered their own names.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

We did not inspect this domain as we had no concerns regarding these key lines of enquiry.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

We did not inspect this domain as we had no concerns regarding these key lines of enquiry.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

We did not inspect this domain as we had no concerns regarding these key lines of enquiry.